CDC Executive Summary:

CDC CONSULTATION ON FAITH AND HIV PREVENTION

December 2006

Introduction

The Centers for Disease Control and Prevention (CDC) recognizes the faith community's influence on knowledge, attitudes, beliefs, and behaviors about health. Since 1996, CDC has provided resources to faith-based organizations and worked to make them part of HIV prevention efforts. Faith-based organizations have conducted many HIV prevention activities. These activities include capacity-building assistance and training programs for faith leaders whose communities have high rates of HIV/AIDS.

CDC held a two-day meeting on "Faith and HIV Prevention" on February 13-14, 2006 in Atlanta, GA. The meeting was held to expand and strengthen CDC's partnerships with faith communities. People who attended the meeting included faith leaders, people who provide HIV services, and public health workers. They discussed the role of faith-based organizations in helping prevent HIV/AIDS. There were 48 people at the meeting, including 29 leaders from many faiths, including Protestant, Catholic, Jewish, Hebrew-Israelite, Muslim, and Buddhism.

Those who came to the meeting were urged to meet these objectives:

1. Share examples of faith-based programs and faith leadership involvement in HIV prevention.
2. Identify religious and theological principles that support HIV prevention.
3. Understand the potential roles and activities that faith leaders may undertake in HIV prevention.
4. Identify strategies to facilitate partnerships between public health and faith communities in support of HIV prevention.

The meeting included four panel sessions. Each session started with comments from faith leaders, which were followed by group discussions. The topics of the four panel sessions included:

- Faith Leadership in Action
- Religious and Theological Considerations for Faith Involvement in HIV Prevention
- Religious and Theological Principles for HIV Prevention
- Faith Leadership in Caring for People with HIV/AIDS

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Discussion Highlights

The following pages are a summary of the panel session discussions. They represent the views expressed and shared by faith leaders who participated in the sessions. They do not represent the official position of the CDC.

Faith leaders are generally in agreement on their role as leaders in the community and their responsibility to the community to address HIV/AIDS. However, they are not always equipped to fulfill that role. The participants indicated that they would like more background guidance, more education or training, or more resources in order to properly disseminate HIV prevention information. Capacity and preparation appeared to be key elements for addressing the effects of HIV/AIDS in their communities.

There is no single over arching theological view of the HIV epidemic or the response of the faith community; there are many such views. Viewpoints may need to be addressed individually. Approaches should be capable of being adapted to the situation, perspective, and capacities of each faith leader individually. Meeting participants emphasized the need for public health to meet faith leaders "where they are" – to offer solutions and suggest actions that are compatible with the leaders' theological viewpoints and parameters. Given the theological differences among the major faith groups, as well as the significant number of differences within those groups and subgroups, what public health requests of faith leaders should be individually suited to them as individuals.

There is no single communication or information approach that will resonate with differing religions, and leaders are not necessarily accepting of one another's approach or viewpoint. What gets the attention of one faith community may be inconsequential to another. What makes sense to one faith community may be nonsense to another and even offensive to a third. While faith leaders may perceive a common responsibility or role, they can be expected to vary widely on their perceptions of what actions they should take, topics they should address, or methods they should employ. Further, they may see different needs for support and different methods to obtain it. To communicate effectively with faith leaders about HIV prevention, it is vital to become familiar with their specific religious viewpoints. Public health should not assume that there is any one perspective, approach, or theological framework that will appear reasonable, actionable, or endorsed by faith leaders generally.

For the most part, faith leaders do not talk about sexuality because they do not know how to address the topic. Participants freely admitted discomfort in providing counseling regarding sexuality, not because they were uneasy with the topic, but because they felt unprepared to conduct a helpful discussion of it, particularly in terms of risk behaviors. It is not something that they normally have been educated in during the course of their professional preparation, nor is it something for which they have found training readily available as their experience and background grows.

Faith leaders, even when advocating prevention and care, typically connect HIV/AIDS with sexual behavior, and each religious point of view should address that independently. This does not mean that they are necessarily negatively judgmental about the behavior or, in fact, judgmental at all. Participants indicated, however, that – even when solidly oriented in favor of care, compassion, and treatment – many faith leaders view the disease as a consequence of some behavior. This results in a perception that people living with HIV could have prevented their infection when, in actuality, they could be "crimeless victims" who became HIV-infected through marital relations, blood transfusions, or other unavoidable means.

Leaders should focus specifically on what affects their specific community. This community

may be a congregation or it may be a population, but it is the primary concern of the faith leader. The community is also the determining factor in any assessment of suitability or feasibility of an active role for that leader to take. Fulfillment of any action by the leader is much more likely if the action is planned with the leader's specific community in mind.

Faith leaders should keep the scope of HIV prevention relevant for the faith community. Faith leaders need to be able to connect with a level of HIV prevention that is appropriate for the religious perspective of their faith community. If "prevention" is translated to mean passing out condoms, then refusal to pass out condoms does not mean that faith leaders are not open to doing other kinds of prevention outreach more in line with their religious perspectives. Effective and actionable prevention approaches involve identifying those activities that faith leaders are comfortable doing and finding ways to build their capacity to do them.

Faith leadership should recognize and appreciate exemplary faith leaders engaged in HIV prevention. One way to develop leaders to address HIV prevention is to recognize and acknowledge those who have already been involved. Opportunities for faith leaders to talk about their role in HIV prevention can help to recruit others and also helps publicizes the work of the faith community. Use the opportunity to do leadership development that educates and motivates younger faith leaders to engage in the work of addressing all health disparities, especially HIV prevention.

Faith leaders should develop partnerships and coalitions to address HIV prevention within their communities. Faith leaders themselves are an important part of increasing HIV prevention within the faith community, but they are only a part of the community and as such are only one part of the solution. HIV prevention within the faith community should be done by the faith community; however, one effective strategy to address HIV prevention is through the development of community based coalitions and partnerships. These connections provide opportunities for faith leaders to gain support and garner resources.

Faith leaders clearly have a role as caretakers, but can often gain from new insights regarding ways in which they can fulfill that role. They can quickly recognize actions that they themselves can take as part of ministering to their congregations, but may not as easily see opportunities for providing care through others such as members of their congregations, other leaders, and larger communities. Focusing attention not only on their individual capabilities, but also on the potential of the community care that they are positioned to empower can result in an extensive environment of care and compassion for those affected by HIV/AIDS.

Faith leaders appear to welcome a relationship with public health, provided that the relationship remains compatible with their religious perspectives and their community obligations. The common interests in the well-being of all people and the provision of care for those in need of care mean there are opportunities for each party in the relationship to help, support and advance the efforts of the other.

Recommendations

Based on the ideas shared and views expressed during the two-day meeting, faith leaders were able to develop the following list of recommendations for engaging the faith community in HIV/AIDS awareness and prevention efforts. Like the Discussion Highlights, they represent the views and opinions of the faith leaders. They do not represent the official opinion of the CDC.

Use multiple channels to reach faith leaders in order to initiate dialogue about HIV prevention. Faith leaders have multifaceted lives and are exposed to – and motivated by – multiple sources of influence.

Direct Communication – Opportunities for direct conversation may be found at conferences, panels, boards, and other instances of community dialogue (at any level), when public health leaders may intersect with faith leaders and impress on them the severity of the HIV/AIDS epidemic, its impact on faith communities, and the valuable role that faith leaders can play in initiating community conversation about it.

Communication Through Peers – Conversations within faith communities present opportunities for faith leaders to dialogue with their counterparts and present rationale, both non-secular and secular, for furthering HIV prevention. Those faith leaders already involved can introduce the topic into discussions or presentations.

Communication Through Constituents – Consultation participants emphasized that even when faith leaders may not be listening to the public health community, they are listening to their congregants, boards, and spouses. When public health convinces the public about the importance of HIV prevention, the message can get through to faith leaders.

Look for ways to make education available to faith leaders. The consultation discussions included numerous expressions of information and training needs.

Understanding HIV/AIDS – Faith leaders, unless they seek it out, have no greater knowledge of this topic than ordinary citizens would. They know what they hear from their communities and colleagues, what they read, and what they encounter at a personal level. They need to be equipped with an understanding of the extent and nature of the epidemic. They need to know more about the disease, the needs of those infected, and the impact on the community. Most of all, they need to understand the nature and danger of the stigma.

Discussion of Sexuality – Faith leaders are often untrained in a counseling role regarding this topic, especially in regard to risk behaviors. They are familiar with religious perspectives of sexuality, but may be unfamiliar with the role of guidance. Identifying those who are willing to enter the discussion of sexuality, but lack the tools and training, may be productive in generating many more open dialogues in many more communities.

Best Practices – Although several participants were able to highlight best practices for the discussion, others appeared to be in search of models for certain activities or approaches. While the consultation discussions juxtaposed requests for clearinghouses with descriptions of resources, it appears that public health agencies at every level would be performing a valuable service simply by providing information referrals and links. Part of this function should include being certain to inform the faith community that public health agencies are a first-line resource for information; it is not clear that this is immediately apparent to them.

Peer Enlistment – Faith leaders are not necessarily prepared to lead one another. A valuable part of their role is their potential to get more faith leaders involved in HIV prevention. They can present the most compelling case for faith involvement, and they have opportunities for discussion. They may not be familiar, however, with the advocacy required to persuade a peer to join an initiative. Public health agencies can provide a resource for materials and motivational processes.

Encourage leaders to open the discussion with their communities and among themselves as the most valuable and over arching step they can take. In most cases, other elements of their role and the activities of the community will follow in

a natural process. In many cases, this first step may be able to open the door to most others, and it may avoid resistance to encouragement to implement HIV testing or other programs.

Focus on the community, not just on the leaders. Many faith leaders are not just responsible to their community, but are also answerable to it. Participants made it clear that faith leaders help shape community viewpoints, but they also listen to the concerns and priorities of their congregants.

Keep it a health issue. Each religious perspective will define its relationship to the epidemic. Public health can understand religious principles and perspectives, but it does not need to interpret them for faith leaders. Care for the entire person means that, as a health issue, HIV/AIDS is well within the faith leader's role; it is not necessary to add it to the menu. It might be said that faith leaders can respond to a health issue far more simply and easily than to a spiritual issue.

Meet them where they are. In approaching the faith community, it is more productive for public health to address the care of those in need than to navigate the nuances of abstinence, condom use, sexual practices, blame, etc. Asking faith leaders to do what they are currently prepared to do will produce a response; asking them to take other positions or actions will produce delays or complications.

Be certain that the terminology used is culturally and situationally competent. The consultation discussions showed that unintentional marginalization can happen easily in addressing such a wide range of cultures and circumstances. For example, reference to one deity may be as inappropriate to one faith as reference to multiple deities might be to another. Declaring HIV to be completely preventable does not sit well with someone who has been infected despite monogamous behavior within a marriage or by an accidental exposure to infected blood; in fact, the statement may serve to increase stigma instead of reducing it.

Make support available to faith leaders who have been involved over the long term. They form the frontline of the faith community in assisting public health efforts, and sustaining their efforts is critical to increasing faith community involvement. They need continuing access to resources, peers, training, and information. Additionally, they need ongoing motivation, both to maintain a sense that their involvement continues to have value and to maintain a priority focus on HIV prevention in the midst of numerous demands on their time and energy.

Conclusion

Faith leaders expressed both an interest in and a need to confront the HIV/AIDS epidemic in the United States. Public health officials and faith leaders can partner to achieve this goal. To confront the epidemic, public health officials and faith leaders should seek more opportunities to find common ground and to build better relationships. They should educate and learn from each other to develop and deliver messages appropriate to both the realities of the epidemic and the principles of faith. By working together effectively, faith leaders and public health officials can do so much more to increase HIV awareness and decrease HIV transmission among the populations that they serve.